North Carolina Department of Health and Human Services
Division of Facility Services
Adult Care Licensure Section
2720 Mail Service Center
Raleigh, NC 27699-2720

For DFS ACLS Office Use Only
License#
FID
Reviewed_____Date_____
Compliance Check Completed:
Date_____By_____
Data Entry_____

Facility Name **Annual License Fee**

RENEWAL LICENSE APPLICATION FOR ADULT CARE HOMES 2007

PLEASE READ CAREFULLY

If you do not submit a complete renewal application with license fees by December 31, 2006 (postmarked), your facility license will not be renewed. Adult care beds are subject to the certificate of need (CON) law (G. S. 131E-176). As of January 1, 2007, unlicensed facility beds will be removed from the state/county inventory and further licensing will be subject to the CON process when bed need in your county is identified.

- This application contains preprinted information from our data systems. If any of the preprinted information has changed, mark through the incorrect information with a red pen and write in the correct information.
- If you wish to request ***changes*** (ownership, capacity, location, facility name), and you expect those changes to occur prior to December 31, 2006, download a change application from our website and submit with the renewal application. Changes must be processed before the renewal application can be processed in order for the new license to reflect the changes.
- Your annual fee must accompany this application.
- Complete All Blanks, if not applicable mark N/A

For the purpose of this application the follow definitions apply:

The following definitions shall apply throughout this application:

(1) "Person" means an individual; a trust or estate; a partnership; a corporation; or any grouping of individuals, each of whom owns five percent or more of a partnership or corporation, who collectively own a majority interest of either a partnership or a corporation.

(2) "Owner" means any person who has or had legal or equitable title to or a majority interest in an adult care home.

(3) "Affiliate" means any person that directly or indirectly controls or did control an adult care home or any person who is controlled by a person who controls or did control an adult care home. In addition, two or more adult care homes who are under common control are affiliates.

(4) "Principal" means any person who is or was the owner or operator of an adult care home, an executive officer of a corporation that does or did own or operate an adult care home, a general partner of a partnership that does or did own or operate an adult care home, or a sole proprietorship that does or did own or operate an adult care home.

(5) "Indirect control" means any situation where one person is in a position to act through another person over whom the first person has control due to the legal or economic relationship between the two.

License No:
Facility ID:

Change Application Attached: _____**Yes** _____**No**

Part A Facility Information

The name on this line is the name of your facility, as it is/will be printed on your license. If it is incorrectly spelled or you have changed the name of the facility, mark through and print in the correct name.

Facility Name:
(Exact name on your current license, name which the facility is advertised or presented to the public.):

Facility Site Address: _____
(physical location of facility) _____
County: _____
Facility Telephone: _____
Facility Fax: _____

Correspondence Mailing Address: (where you want to receive mail including the license from DFS):
Addressee: _____
_____

Part B Operation Disclosure

1. **Certified or Qualified Administrator**: You **must** include the administrator's certificate number.

Name: _____

Address: _____City _____

State ____ Zip_____County_____Telephone#: __(___)_____

Fax (__)_____

Administrator Certificate No. (**if 7 beds or more**)_____

Percentage Interest in this Facility: _____

2.MANAGEMENT COMPANY: If facility is managed by a company ***other than the licensee***, provide the following information about the Management Company:

Name _____
Street/Box: _____
City _____ State: _____ Zip: _____
Telephone: _____ Fax: _____

Percentage of Ownership Interest in this Facility: _____

3. LEGAL IDENTITY OF LICENSEE

The preprinted name, address and phone number(s) is the data we currently hold for the facility/business owner. This is the name printed as "licensee" on the license. If this name appears incorrectly, please mark through in and print the name, as it should appear on the license. If any information is missing, please complete.

Licensee on current License _____

Street/Box: _____

City _____ State: _____ Zip: _____

Business Phone: _____ Fax: _____

Federal Tax ID number of Owner/Licensee**:** _____

Percentage of Ownership Interest in this Facility: _____

Legal entity is: ___ For Profit __ Not For Profit

Legal entity is: ___ Proprietorship ___ Partnership ___ Limited Liability Company

___ Corporation ___Government Unit ___ Limited Liability Partnership

4. *If the "licensee" is a corporation or partnership list the name of the Executive Officer or General Partner.*

Executive Officer: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Business Phone #: (____) _____ Fax (____) _____

Percentage of Ownership Interest in this Facility: _____

5. **Building Owner:** If the above entity (partnership, corporation, etc.) ***does not*** own the building from which services are offered, provide the following information:

Name: _____

Street/Box: _____

City _____ State: _____ Zip: _____

Business Phone: ( ) _____ Fax: ( ) _____

Percentage of Ownership Interest in this Facility: _____

Part C Ownership Disclosure

1. OWNERS, PRINCIPLES, AFFILIATES, SHAREHOLDERS

Complete the information below on **all** individuals or entities who are owners, principles, affiliates or shareholders holding an interest of **5% or more** of the applicant entity. Attach additional pages if necessary.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone # of Shareholder: (_____) _____ Fax (_____) _____

Percentage interest in this facility: _____ Title: _____

List the names of other Family Care/Adult Care homes in which you are the owner or affiliate_____

_____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone # of Shareholder: (_____) _____ Fax (_____) _____

Percentage interest in this facility: _____ Title: _____

List the names of other Family Care/Adult Care Home in which you are the owner or affiliate_____

_____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone # of Shareholder: (_____) _____ Fax (_____) _____

Percentage interest in this facility: _____ Title: _____

List the names of other Family Care/Adult Care homes in which you are the owner or affiliate_____

I attest that this is a true account of all owners, principles, partners, and affiliates of shareholders who hold an interest of 5% or more of the entity applying for or renewing this license:

_____ _____ _____

Signature Title Date

Print Name _____ Phone Number_____

2. EXTENSIONS IN OWNERSHIP

North Carolina General Statute also requires information about "affiliates" of the applicant entity.

(a) Is the applicant entity controlled by any other organization that operates licensed adult care facility? Yes _____ No _____

(b) Does the applicant entity control any other organizations that control any other licensed adult care facilities? Yes _____ No _____

(c) Does the applicant entity control other adult care homes? Yes____ No_____

(d) If the answer to (a), (b) or (c) above is "Yes" list the name of the other organization(s) and provide the requested information on the individuals who control 5% or more of that organization. Attach additional pages if necessary.

Person/Organization Name: _____
Facility Name: _____ Federal Tax ID Number: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Organization Phone #: (_____) _____ Fax (_____) _____
Percentage of ownership Interest_____
List the names of other Family Care/Adult Care homes in which you are the owner or affiliate_____
_____

Person/Organization Name _____
Facility Name:_____ Federal Tax ID Number: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Organization Phone #: (_____) _____ Fax (_____) _____
Percentage of ownership Interest_____
List the names of other Family Care/Adult Care homes in which you are the owner or affiliate_____
_____

Person/Organization Name: _____
Facility Name: _____ Federal Tax ID Number: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Organization Phone #: (_____) _____ Fax (_____) _____
Percentage of ownership Interest_____
List the names of other Family Care/Adult Care homes in which you are the owner or affiliate_____
_____

The following information will be used for internal compliance history checks as required by G.S. 131D-2b(1). We ask that you voluntarily provide your social security number with the understanding that it will be used only as an identification number for internal record keeping and data processing. Incomplete data will delay the renewal application being processed.

Category	Name	SSN	Contact Number	Percentage of interest as reported on pages 2-5
Administrator				
Licensee				
Licensee				
Building Owner				
Executive Officer				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				
Owner, Principles, Affiliates or Shareholder				

Please use additional paper and attach if needed.

Reminder: failure to complete this information will delay the renewal process.

Part D Census Data

Data reported for items one through seven should be for September 30, 2006. The total in question #1 must equal the total in question #2. If these are not the same this will delay your renewal.

1. **Total number of residents in facility on September 30, 2006: _____**

2. **Please give the number (1,2,3 etc) of residents currently in facility as indicated:**

Resident Age - years	Male	Female	Total
18 - 24			
25 - 34			
35 – 49			
50 - 64			
65 - 74			
75 - 84			
85 or older			
TOTAL			

3. **Please give the number (1,2,3, etc) of residents currently in facility with a physician's diagnosis of the following: a) Mental Illness (MI) which includes a psychiatric illness but does <u>not</u> include mental retardation, developmental disabilities or Alzheimer's/Dementia; b) Mental Retardation/Developmentally disabled (MR/DD) or c) Alzheimer's Disease or related dementia. If a resident is dually diagnosed, only count the resident once, based on the primary diagnosis.**

Resident Age - years	MI	MR/DD	Alzheimer's/Related Dementia
18 - 24			
25 - 34			
35 – 49			
50 - 64			
65 - 74			
75 - 84			
85 or older			
TOTAL			

4. **On September 30, 2006, number of residents receiving Medicaid reimbursed Basic Adult Care Home Personal Care (not Enhanced): _____**

5. **On September 30, 2006, number of residents receiving Medicaid reimbursed Enhanced Adult Care Home Personal Care: _____**

6. **On September 30, 2006, number of residents on State/County Special Assistance (SA): _____**

7. **On September 30, 2006, number of private pay residents: _____**

8. **Current total <u>monthly</u> private pay charge (average base plus add-ons if more than one price) for:**

   Monthly Private Room (1bed/room) $_____
   Monthly Semi-Private (2 beds/room) $_____
   Monthly 3 or more beds/room $_____

9. **Total number of discharges (excluding deaths) for the 12-month period of October 1, 2005 - September 30, 2006: _____**

10. **Total number of admissions for the 12-month period of October 1, 2005 - September 30, 2006: _____**

11. **Total number of deaths for the 12-month period of October 1, 2005 - September 30, 2006: _____**

12. **Licensed Capacity (as it appears on License) _____**

13. **Is your facility advertised, marketed, or promoted as providing a special care unit for residents with special needs such as Alzheimer's Disease or related disorders, mental health disabilities, or developmental disabilities? YES___ NO___**

14. ***If <u>"YES,"</u> prepare a disclosure statement according to the attached "Format for Special Care Unit Disclosure Statement" and submit it with this application unless such a statement has already been submitted. If your disclosure statement has been revised, please submit the revised statement, which must also be provided to the special care unit residents or their authorized representative.***

15. **Check any that apply:**

    - ❑ **Alzheimer's <u>Special Care Unit</u> in facility (Rules 13F .1300 apply) # of beds _____**
    - ❑ **Mental Health Disability <u>Special Care Unit</u> (Rules 13F .1400 apply) # of beds ____**

16. **Check if apply:**

    - ❑ **This Adult Care Home serves <u>Only</u> elderly persons.**

      ***Persons age 55 or older or who have a primary diagnosis of Alzheimer's disease or other form dementia that require assistance with activities of daily living*.**

Authenticating Signature: The undersigned submits this application for licensure for the year 2007 in accordance with Article 1 Chapter 131 D of the General Statutes of North Carolina and to the rules adopted there under by the North Carolina Medical Care Commission (10A NCAC13F) and certifies the accuracy of this information.

Signature: _____ Date: _____
Print Name _____ Phone Number _____

<u>Please be advised</u>, the license fee <u>must</u> accompany the completed application and be submitted to the Adult Care Licensure Section, Division of Facility Services, <u>prior</u> to the issuance of an Adult Care license.

Staff Turnover Rate Information for Adult Care Homes **Form Questions? Call Jan Moxley (919) 855-4429**

Please complete the following information regarding aide (e.g., nurse aides, personal care aides and/or home management aides) turnover rates. This information is being requested to enable the Division of Facility Services and the Department of Health and Human Services (DHHS) to track turnover rates in nursing homes, adult care homes and home care agencies. The information you provide by answering questions below will be compiled and aggregated with other responses by type (i.e., nursing homes, adult care homes, home care agencies). Collection and analysis of data on an annual basis helps measure the size and stability of this workforce over time. **This information is not filed as a part of your renewal application.**

1. Licensed as: _____ACH _____Nursing Home _____Combination facility _____Home Care Agency
2. Licensed bed capacity: _____/Beds
3. Are you an NC NOVA Special License recipient? _____Yes _____No

For the period October 1, 2005 through September 30, 2006:

(IF NONE WRITE "0")	Full Time	Part Time
3. How many aides at your facility **QUIT** their jobs?		
4. How many aides at your facility were **FIRED** or terminated?		
5. How many **NEW** aides were hired?		
6. How many aide positions are currently budgeted?		
7. How many aides were on your payroll on ***September 30, 2006?***		

8. Do you feel that you have an *Aide Turnover Problem?*

_____No problem _____Yes, it's a mild problem _____Yes, it's a substantial problem

Circle one response for each question below:	Almost Impossible	Very Difficult	Slightly Difficult	Not Difficult
9. How difficult has it been to find enough aides to fill vacant positions?	**1**	**2**	**3**	**4**
10. How difficult has it been for your facility to retain aides?	**1**	**2**	**3**	**4**

About your leadership positions…..

11	In what **MONTH** and **YEAR** did your current **ADMINISTRATOR OR EXECUTIVE DIRECTOR** begin working in that position?	**MONTH**	**YEAR**
12	Is your current **ADMINISTRATOR OR EXECUTIVE DIRECTOR** working on a regular basis, or "filling in" on a temporary or interim basis? *(CIRCLE ONE NUMBER)*	**1**: REGULAR/ PERMANENT	**2:** INTERIM/ TEMPORARY
13	*If your current* **ADMINISTRATOR OR EXECUTIVE DIRECTOR** *started within the last year*, please circle how many *DIFFERENT OTHER* persons have served in that position since October 1, 2005? (DO NOT include "temporary" or "acting" administrators) *(CIRCLE ONE NUMBER)*	**0** **1** **2** **3**	**4 OR MORE**
14	In what **MONTH** and **YEAR** did your current **RESIDENT CARE DIRECTOR** begin working in that position?	**MONTH**	**YEAR**
15	Is your current **RESIDENT CARE DIRECTOR** working on a regular/ permanent basis, or "filling in" on a temporary or interim basis? *(CIRCLE ONE NUMBER)*	**1**: REGULAR / PERMANENT	**2:** INTERIM/ TEMPORARY
16	*If your current* **RESIDENT CARE DIRECTOR** *started within the last year*, then please circle how many *DIFFERENT OTHER* persons have served in that position since October 1, 2005? (DO NOT include "temporary" or "acting" supervisors) *(CIRCLE ONE NUMBER)*	**0** **1** **2** **3**	**4 OR MORE**

See next page for statewide turnover survey results from previous years

Results of Turnover Data Collected in Prior Years

Turnover Rates	2000	2001	2002	2003	2004	2005
Nursing Facilities	103%	102%	95%	105%	107%	117%
Adult Care Homes	119%	113%	115%	109%	107%	111%
Home Care Agencies	53%	50%	37%	49%	41%	46%

For instructions on how to calculate the turnover rate for your facility/agency go to: www.aging.unc.edu/research/winastepup/ and click on link for turnover calculations.

To insure you can refer back to the information on the staff turnover form, **make a copy** prior to mailing the completed original to Division of Facility Services.